EXHIBIT A

Volume: I

Pages: 1 to 84

UNITED STATES DISTRICT COURT

DISTRICT OF MASSACHUSETTS

C.A. NO. 04-10738-MLW

EBEN ALEXANDER, III, M.D.,

Plaintiff,

vs.

BRIGHAM AND WOMEN'S PHYSICIANS ORGANIZATION, INC., successor to BRIGHAM SURGICAL GROUP FOUNDATION, INC. BOSTON NEUROSURGICAL FOUNDATION, INC. DEFERRED COMPENSATION PLAN, BRIGHAM SURGICAL GROUP FOUNDATION, INC. FACULTY RETIREMENT BENEFIT PLAN COMMITTEE ON COMPENSATION OF THE BRIGHAM SURGICAL GROUP FOUNDATION, INC., and PETER BLACK, M.D.,

Defendants.

DEPOSITION OF STEPHEN SADOWSKI

Wednesday, September 13, 2006; 2:06 p.m.

Nystrom Beckman & Paris, LLP

10 St. James Avenue, Boston, MA

Court Reporter: Kathryn L. Santo

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salary guidelines document that you reviewed?
A. I'm sorry?
Q. What do you recall about the Harvard salary guidelines document that you reviewed? What is it in substance?
A. It was -- to the best of my recollection, it was a statement of Harvard Medical School's salary guidelines for faculty. I believe it was dated in the late '90s, to the best of my recollection.
Q. And was it a one-page document, or was it a thick document?
A. No. It was a several-page document, I think. Five or six pages.
Q. Have you reviewed -- have you completed your answer, to the best of your knowledge?
A. To the best of my knowledge, I have.
Q. Okay. Have you reviewed the expert report of Professor Stein?
A. I have not.
Q. Could you please just briefly take me through your education and employment background?
A. Certainly. To the best of my recollection, I graduated from Clark University in

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Worcester, Mass. with a bachelor of arts in 1982. I have a graduate certificate of special studies in administration and management from Harvard extension, and I have a masters in business administration from Boston University where I graduated in 1988. My -- that's my educational history.
Q. What was your undergraduate degree in?
A. My undergraduate degree was dual major in psychology and philosophy.
Q. Okay. What did you do after you got your MBA at BU?
A. Let's see. To the best of my recollection, I went to work at New England Medical Center for approximately three years as the administrator of the Department of Ophthalmology. And subsequent to that, I believe it was June of 1991 when I joined ECG, and I have worked there since.
Q. What are your duties and responsibilities at ECG?
A. In general description? I have responsibility for marketing and selling work, for performing work, for supervising and developing my

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professional staff, and for the oversight of the day-to-day activities of my office, which has administrative infrastructure as well.
Q. And are you a supervisor of employees of the professional staff?
A. Yes, I am.
Q. And how many people do you supervise?
A. To the best of my knowledge, approximately ten.
Q. And how many folks are in ECG's Boston office altogether?
A. Approximately 12 professional staff. And to the best of my knowledge, I would say approximately six or seven administrative, nonprofessional staff.
Q. Do you have any top-hat plans in place for any of the employees at ECG?
A. To the best of my knowledge, we do not.
Q. As far as your consulting work that you perform in your role at ECG, can you just give me a brief and general description of what you do?
A. Certainly. My practice is focused principally with academic medical centers where I assist clients on a broad range of issues related

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to the organization management and financing of the activities of faculty at the medical school or teaching hospital. The nature of that work tends to be on performance improvement.
Q. Have you ever been consulted to structure a compensation program from scratch?
A. Yes, I have. To the best of my knowledge, I've done it a number of times.
Q. So is it fair to say that your role consists of structuring compensation programs and improving performance at places in which a compensation program is already in place?
MS. HUBBARD: Objection.
A. Could you repeat the question?
Q. I'm just trying to get a sense of whether you, as a consultant, go into these academic medical centers and set up the compensation programs or there's one already in place and you work to improve it or both?
A. To the best my knowledge or description, I'd say both. Most often, there is a compensation program of some type in place, but certainly, on occasion, there are circumstances that create the need for new compensation programs that I have been

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involved in.
Q. Can you give me an example of when you've gone in and worked with no compensation program in place and you've designed it from scratch?
A. Certainly. Again, in general description, to the best of my knowledge, an academic medical center client that separately incorporated their faculty practice plan, which, in essence, required the termination of employment of roughly 200 faculty, and as we developed the new corporation for the faculty physicians, we developed a compensation program for them as well, as an example.
Q. Okay. We'll come back to your current work. But I just want to go back into -- reach back into your past employment and get a sense of what your duties were when you were at New England Medical Center.
A. Certainly.
Q. What were they?
A. As a department administrative for the ophthalmology department.
Q. That was your only role there; right?
A. That was my only role.

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Q. Okay. Yes.
A. To the -- again, to the best of my memory, I provided management support to the chairman of the department; and was responsible for the day-to-day management of the finances of the department; the oversight of the billing activities, professional fee billing activities of the department; oversight of the ambulatory clinic and its associated staff; as well as a variety of administrative support activities associated with the research and teaching programs of the department. Again, it's all to the best of my memory.
Q. Did you have any involvement in the compensation plan while you were at New England Medical Center for the staff there?
MS. HUBBARD: Objection.
A. For the faculty physicians?
Q. Yes.
A. That's -- to the best of my memory, yes, some involvement in compensation plans, the distribution of compensation.
Q. What was --
A. The accounting for it, principally the

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accounting for it.
Q. Okay. Anything beyond accounting?
A. To the best of my memory, I was involved in the development of a particular specific compensation plan for the chairman of the department when that chairman stepped down from that role but remained with the department.
Q. So that was an individualized plan?
A. Yes. That's an accurate characterization.
Q. Did you have any involvement in -- well, let's take that individualized plan. Was there any deferred compensation plan in connection with that?
A. Not to the best of my knowledge.
Q. Did you have any involvement at New England Medical Center with the faculty physicians deferred compensation plans?
MS. HUBBARD: Objection.
A. Not to the best of my knowledge.
Q. Did you have any involvement while at New England Medical Center with the faculty -- with any top-hat plans that may have been in place?
A. Not to the best of my knowledge.
MS. COOK: We might as well mark this as

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the first exhibit.
(Document marked as Sadowski Exhibit 1 for identification)
Q. Mr. Sadowski, I'm handing a document that's been marked as Exhibit 1, and it's entitled, "Defendants' Rule 26(a)(2) Expert Disclosure." Do you recognize this document?
A. (No verbal response)
Q. I can --
A. Yes, I do.
Q. Okay.
A. It looks familiar.
Q. Okay. And a few pages into the document, is that your CV?
A. Yes, it is.
Q. Okay. And in that first paragraph, it mentions that your several years in operations rules with health maintenance organizations?
A. Yes. That's correct.
Q. What is that referring to?
A. During my business -- while in business school from -- to the best of my recollection, it was 1986, '87 approximately I worked for Harvard Community Health Plan as an operations analyst.

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wage and physicians who receive, by comparison, substantially greater compensation. And again, based on my experience and understanding of IRS requirements under qualified programs, those tests will often limit the amount of compensation that can be devoted to the retirement program.

In addition, there are statutory caps as well on the magnitude of funds that can be devoted to retirement. And so oftentimes, at least in those circumstances, highly compensated physicians are looking for opportunities to optimize the amount of their contribution or their company's contribution in the group practice to their retirement program, as an example.

Q. Did you say the physicians were looking to optimize the amount of contributions to their retirement programs?

A. In -- sometimes. Oftentimes, that's the case. I would say it depends on the nature of the specialty. Often, physicians, by specialty, vary in the degree of -- or in the magnitude of compensation -- are eligible to earn or what the market will pay.

Q. Okay. So going with your example -- and

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I believe you said that there were two challenges that you used as examples; the IRS limitation and statutory caps?

A. Yes.

Q. Okay. So how would you use or would you use a top-hat plan in these circumstances?

A. In those circumstances, it would provide an opportunity for that group practice to enhance their fringe benefit program by providing an opportunity for the more highly compensated physicians to increase their retirement savings, their retirement opportunities.

Q. You're familiar with the compensation program that was in place at Harvard Medical School and the BSG? Do you know what I mean by the "BSG"?

MS. HUBBARD: Objection.

A. Yes. I know it as the Brigham Surgical Group.

Q. Right.

A. I have read the documents -- is the degree of my familiarity.

MS. HUBBARD: Just to clarify, are you asking about the professional staff compensation policy specifically?

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MS. COOK: Just generally. I mean --

Q. Let me strike that and ask a better question. My question should have been: Do you have any personal knowledge about the compensation structure at the BSG outside of this case?

A. I do not.

Q. Okay.

A. To the best of my knowledge.

Q. And so your familiarity with the compensation structure at the BSG is based on your review of the documents in this case?

A. It's -- yes.

Q. Is that fair to say?

A. To the best of my knowledge, that's fair.

Q. Now, based on your review of the documents in this case, are the two challenges that you mentioned present for the BSG?

MS. HUBBARD: Objection.

A. The two challenges -- I'm not sure what you mean by the "challenge."

Q. Well, you said that two challenges -- challenges arise as they relate to retirement benefits. And then you gave a couple of examples.

A. Yes.

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Q. The IRS limitations.

A. Yes. I'm not familiar with why the BSG may have -- what drove them to develop a deferred compensation program or what put them in place. I could speculate on why they put one in place, but I don't have -- I'm not sure.

Q. You have no personal knowledge as to the genesis of the UDC or the FRBP?

A. Not -- no, no personal knowledge.

Q. Do you have an opinion as to the purpose of these plans?

A. I -- yes. I have an opinion on the purpose. My assumption is that those plans -- that plan was put into place to create retirement savings opportunities that were otherwise constrained by the market and then regulation -- regulation rather than the market; that, two, they were likely put into place as a vehicle for recruitment so that group could offer an enhanced compensation opportunity.

And my opinion would also be that they were likely put into place a retention vehicle to -- in an effort to bond employed physicians to the group. Again, that's all speculative on my

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part. But I would guess that that would be the reason -- some of the reasons more likely drove the development to the plan.
Q. Well, I'm a little confused. I'm trying to ascertain whether part of your expert testimony is the purpose of these plans.
A. Part of my expert testimony is -- yes -- about the purpose of these plans, I believe. That's why I'm --
Q. Okay. But I thought that you just testified that these were just assumptions and speculation?
A. Yes, because I have no knowledge why the Boston -- Brigham Surgical Group put their plan into place. I can only speculate as to why they may have put this plan into place, based on my experience elsewhere.
Q. Okay. And is it also speculation as to the three purposes you just gave me?
A. Yes. I would speculate that those are -- the three purposes I gave you, I'm speculating, are reasons they may have put that plan into place.
MS. HUBBARD: Colleen, can we take a break here? I'd like to just confer with the

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witness for just a moment.
MS. COOK: I'd rather just finish up on this little section.
MS. HUBBARD: I think we're not in the middle of a question right here.
MS. COOK: Let me just ask a couple of follow-up questions.
(Pause)
Q. Do you intend to offer testimony at the trial in this action concerning the purpose of these plans as you just laid out? And you gave me three factors -- three reasons.
A. Yes. To the best of my knowledge, that's my understanding.
Q. What is the basis of your testimony?
A. My experience with the use of those plans by group practices, practice plans at academic medical centers.
Q. Okay. But you're speaking generally; right?
A. Yes.
Q. When you referred to those plans in your answer just now, you're not talking about the use of the UDC and the FRBP?

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A. I am not.
Q. Okay. So you're talking generally about your experience at academic medical centers, aside from Harvard?
A. I believe that's a reasonable characterization, yes.
Q. Is it fair to say that the testimony that you anticipate giving at trial is -- and the three -- specifically, the three factors that you just gave me as reasons for the UDC and the FRBP is based on experience with institutions completely unrelated to Harvard?
A. Yes. That's fair.
Q. Have you, in your experience, seen plans like the UDC or FRBP -- I should say not like but identical to the UDC or FRBP at any other academic medical centers?
A. I -- to the best of my knowledge, I wouldn't say identical to.
MS. COOK: We can --
MS. HUBBARD: I'd like to take a break now.
MS. COOK: -- take a break.
MS. COOK: Thanks.

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(Brief recess taken from 2:47 p.m to 2:54 p.m.)
A. I just wanted to take the opportunity to clarify -- if that's okay -- my testimony from before. That when I referred to speculating on this, that is my opinion based on both my experience and review of the documents that I referenced earlier.
Q. And I think that you already testified that your experience -- you have no experience with Harvard; is that right?
MS. HUBBARD: Objection.
A. No experience with Harvard as it relates to compensation program or compensation guidelines, which is what I believe the question was.
Q. Well, you have no personal experience with consulting for Harvard; right?
A. Not for Harvard Medical School. I do currently have an engagement with Partners Health System, which is an affiliate of Harvard.
Q. Right. And does your engagement with Partners consist of examining deferred compensation plans for them?
A. It does not.

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A. Based on my reading of the compensation policy, I would say yes. I would just -- I'm not sure what it would mean to "opt out."
Q. Well, for example, there's no way for a BSG surgeon to say, I don't want my funds to go into the FRBP?
MS. HUBBARD: Objection. That goes beyond the scope of what Mr. Sadowski's reviewed.
A. Yeah. I don't know why the -- because the opting out would be to say, I don't want any compensation.
Q. No. By "opting out," I mean do something else with the funds.
A. I would -- I would agree that would be highly unusual to do something like that.
Q. And it's not actually permissible; right? -- under the compensation policy in this case?
MS. HUBBARD: Objection.
A. I -- excuse me for -- it seems like a funny question because I don't -- it's not -- it wouldn't be normal to say that I would tell -- in any circumstance that you would tell your employer, Don't pay me.

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Q. I'm not suggesting, Don't pay me. I'm suggesting the surgeon having the ability to do something, other than have the funds directed to these three places that are set out in the --
A. To circumvent the --
Q. -- compensation policy.
A. -- compensation program, to establish their own compensation program?
Q. Essentially.
A. I would -- that would be highly unusual, yeah. It doesn't appear to me from anything I read that they would have an option --
Q. Right. And in fact --
A. -- to develop a unique compensation program for themselves.
Q. Mr. Sadowski, do you intend to testify that highly profitable physicians have significant bargaining power?
A. Highly profitable physicians have significant bargaining power? Relative to their recruitment and retention?
Q. Actually, I'd be most interested in their bargaining power relative to negotiating the terms of their deferred compensation plans.

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A. My opinion would be that individual physicians wouldn't necessarily have a strong bargaining position but that a cohort of highly compensated physicians would have a strong bargaining position.
Q. And how would a cohort of highly compensated physicians have strong bargaining position with respect to negotiating the terms of their deferred compensation plan?
A. Presumably, they would, by threat of departure, termination.
Q. Is it your opinion that the BSG surgeons had the ability to negotiate the terms of the UDC and FRBP?
A. That's unclear to me from the documents that I read because I'm unaware of the government's mechanism of the group, have a working knowledge of the government's working knowledge of the group where --
Q. So is it fair -- sorry.
A. Where presumably that would happen.
Q. Is it fair to say then that you do not intend to offer any testimony or an opinion at trial concerning the bargaining power of the BSG

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surgeons?
MS. HUBBARD: Objection.
A. Again, I'm not certain what I would offer an opinion as I -- based on what I said earlier, which is that a group of highly compensated physicians would have a bargaining -- "bargaining" position, to use your term, to affect the design of the -- of the deferred compensation program potentially.
Q. Okay. So are you speaking generally?
A. You asked the question generally.
Q. No, I didn't. I think I asked about the BSG surgeons specifically and whether you intended to offer an opinion at trial concerning whether they had bargaining power with respect to negotiating the terms of the UDC and the FRBP. I think that was pretty specific.
A. Yeah. That's specific. I -- I don't believe I could offer testimony on their bargaining power.
Q. What is the basis for your opinion that -- your general opinion that a cohort of highly compensated physicians have a bargaining position?

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A. Their ability to terminate their own employment.
Q. Well, what's the basis of your opinion?
A. I've seen circumstances elsewhere where groups of highly compensated physicians have left an academic practice.
Q. Because they were unable to negotiate the terms of their deferred compensation plans?
A. They were unable to negotiate the terms of their compensation, I would say.
Q. Well, what about their -- what about -- were these top-hat plans in the circumstances that you're talking about?
A. No, they're not -- in the circumstance I was referencing, I was not referring to a top-hat plan.
Q. Okay. Do you --
A. I'm talking about the bargaining position of a group being able to -- of highly compensated surgeons being able -- physicians being able to influence the design of a -- of their compensation program.
Q. But there was no top-hat plan in relation to the circumstance that you're describing?

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A. Not in relation to -- not that I'm aware of in the circumstance. There may have been, but not to my knowledge, in that circumstance.
Q. Do you have any experience in which you can tell me that there was a group of highly compensated physicians who exhibited bargaining power with respect to negotiating the terms of top-hat plans?
A. Nothing comes to mind at the moment.
Q. What about deferred compensation plans generally?
A. Deferred compensation plans generally, I would say, yes, that there are examples where groups of physicians, in essence, help drive the implementation of a deferred compensation program.
Q. But those plans were subject to all of ERISA's substantive protections; right? They weren't top-hat plans?
MS. HUBBARD: Objection.
Q. Do you know what I mean by that?
A. No. Please explain.
Q. Okay. You're familiar with top-hat plans?
A. Yes.

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Q. Okay. What's your understanding of top-hat plans?
A. They are opportunity under ERISA to, in essence, provide, depending on their construct -- and there's a variety of constructs of tax-deferred retirement opportunity -- that extends beyond qualified plans for a select group of management or highly compensated employees.
Q. Are you aware that an underlying rationale for top-hat plans is that the folks that would be covered by the plan have significant bargaining power?
MS. HUBBARD: Objection.
A. I'm not sure what you mean by "significant bargaining power" --
Q. Well, that they would be able to --
A. -- as a rationale for the --
Q. That they would be able to have the ability to negotiate the terms of their deferred compensation plans. That's what I mean by that.
MS. HUBBARD: Objection.
A. Not in my experience. I have individual negotiations over the terms of the deferred compensation plan.

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Q. Okay. And individual -- what do you mean by that?
A. That in the case where a deferred compensation program exists, individuals don't have, to use your term, "bargaining" authority to set the terms and conditions of participation in that program.
Q. What were you referring to when you said "individual negotiation"?
A. Its bargaining position. I assume when you said "bargaining position," bargaining means negotiation.
Q. Okay. I'm just trying to understand. Are you saying that in context of the deferred compensation programs that you've seen in your experience, there is or isn't individual negotiation? That's what I'm --
A. There is not.
Q. There's not. Okay. And are the deferred compensation programs that you're referring to -- are those top-hat plans?
A. Yes. Top-hat plans is a general description of --
Q. Of the deferred compensation programs?

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A. Of deferred compensation programs but -- yes.
Q. Well, not all deferred compensation programs --
A. Not all deferred --
Q. -- are top-hat --
A. -- compensation programs is not --
Q. -- plans; right?
A. That's correct. It's a broad range of constructs that we can term top-hat plans.
Q. Right. And is it your understanding that the people that would be covered by the top-hat plans possess bargaining power with respect to negotiating the terms of the compensation plans, deferred compensation plans?
MS. HUBBARD: Objection. Colleen, just to clarify, are you saying bargaining power with regard to their individual plans or just by virtue of their position? I'm not sure it's entirely clear, the context about what you're asking.
Q. Do you understand what I'm asking?
A. I'm not totally clear on --
Q. Okay.
A. I think you're trying to get something

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specific, and I want to --
Q. Let's break it down.
A. -- make sure I'm responsive.
Q. You're talking about top-hat plans --
A. Correct.
Q. -- right? Let's just say --
A. Deferred compensation programs, but sure, top-hat plans.
Q. Let's call it a top-hat plan.
A. Okay.
Q. And is that a group plan, or is that an individual plan?
A. It is a group plan.
Q. Okay. And with respect to the terms of that group plan, is it your understanding that the people that would be covered by that plan have bargaining power with respect to negotiating the terms of that plan?
MS. HUBBARD: Objection.
A. I -- I would -- I'm sorry. I guess I don't like the term "bargaining power." They would exert influence -- they would certainly be able to exert influence as the -- presumably over the nature, design of the plan.

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Q. And how would they do that?
A. As -- in a circumstance where it's management, as managers with responsibility for the compensation program, they would do it. And circumstances where it's highly compensated employees, they would presumably do it by virtue of stature and concerns about the threat of departure and termination.
However, you know, if there's -- depending on the nature of the government's structure, the degree to which those groups can or cannot influence the construct of the plan is real or not real.
Q. So if I boil it down, you're saying it basically depends on the governing structure?
A. I believe it depends on the governing structure.
Q. But you don't know anything about the BSG's governing structure; right?
A. I do not.
Q. Have you published anything on top-hat plans?
A. I have not, and I don't believe, to the best of my recollection, that I referenced them in

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what I have published. I may have, but I don't believe so.
Q. Does your CV, which is contained within Exhibit No. 1, list all of your publications and presentations to date?
A. It does not.
Q. It does not?
A. It does not.
Q. Do you -- can you list the missing ones for me?
A. I'll be --
Q. Off the top of your head or you can provide them to us.
A. I would provide it. I'd rather to that.
MS. HUBBARD: We'll do that.
Q. That's fine. No problem.
A. Yeah. I'll be pleased to do that.
Q. In your experience, have you any knowledge of top-hat plans being invalidated?
MS. HUBBARD: Objection. Invalidated by court?
MS. COOK: No, not necessarily by a court.
MS. HUBBARD: I'm not sure I understand

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what you're asking.
Q. Well, in your experience, have you ever come across any challenges to the validity of a top-hat plan?
A. Not that I can recall.
Q. Is this a first time that you've seen a faculty in this case -- a faculty physician challenge the validity of a top-hat plan?
A. Yes, my first experience.
Q. And other than your personal experience, do you have any knowledge whatsoever of a top-hat plan being invalidated?
A. Not that I can recall.
Q. Hypothetically speaking, if you were consulted to go into an academic medical center and structure a compensation program, what factors would you consider in designing a top-hat plan?
A. First, I would say that I would not design the top-hat plan. That is a -- in my experience, a construct of a plan as a highly technical area. My expertise is not in the designing construct of those.
Q. Would it be an element of what you would suggest to the academic center?

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A. It is an element of something I suggest they consider.
Q. But you wouldn't be responsible for the design of that?
A. Not the design of that.
Q. Just conceptually, you would --
A. Conceptually, in the same --
Q. -- include it in your suggestions?
A. In the same manner that we might suggest that we have time-off policies and tuition-assistant policies and other types of benefit-related policies that need to be funded or financed by the business enterprise.
Q. Could you take a look at, please, in Exhibit No. 1 -- your expert report is attached to Exhibit No. 1; is that right?
A. Yes.
Q. In the first paragraph of your expert report, second sentence reads, "I specialize in assisting academic medical center clients to enhance their financial operational and programmatic performance by, among other things, designing appropriate compensation programs for some physicians."

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A. Yes.
Q. Do you see where it states that?
A. I do.
Q. Okay. Is there a typical model for a compensation program that you would suggest to an academic medical center?
A. No. There is -- there is not a typical model.
Q. No? It varies by client?
A. It varies by client, given the various constructs of academic medical centers that differ, given their different objectives.
Q. So it really has to be individualized; is that right?
A. Otherwise, I wouldn't be in business as much as I am. Yes, that's correct.
Q. Is that a yes?
A. Yes. If I could pull it off the shelf.
Q. It makes it more interesting, though; right?
A. It absolutely does.
Q. Who is involved, typically, in your experience, in the design of compensation program for the faculty physicians?

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A. Again, that would, in my experience, vary, in different circumstances, depending on the culture and nature of different academic medical centers. We can have a highly participatory process, in terms of the involvement of faculty and the design of compensation program.
At one extreme to the other extreme, we can have a very top-down approach to it in which it's designed by a leadership team and implemented and everything in the range in between.
Q. You don't have any personal knowledge of the way that the compensation scheme, as presented in the BSG compensation policy was --
A. I do not.
Q. -- originated?
A. I do not. I guess, in my own qualification, I would add to that is in some of Dr. Mannick's testimony or in his -- to the best of my memory in looking at his deposition, he did comment on discussions with -- if I remember correctly, discussions with the dean about putting the deferred compensation program in place. That's the extent of my --
Q. Do you concern yourself with whether --

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when you're structuring a compensation program, whether the design of the deferred compensation plan would qualify as a top-hat plan?
A. I do not.
Q. That would be for somebody else?
A. That would be the technical expert on the design of that nonqualified plan.
Q. Can you take a look at, please, Paragraph 6 of your expert report.
A. Mm-hmm.
Q. The first sentence reads, "Academic medical centers and their affiliated physician groups generally seek to design and maintain physician compensation programs that provide appropriate incentives for clinical care on one hand and teaching and research on the other."
A. Mm-hmm. Yes.
Q. Can you explain to me a little bit of what you mean by that statement?
A. The physician compensation program at an academic medical center in a group practice, the practice plan is the economic construct of the business enterprise because anywhere from 40 to 60 percent of the business's expenses of the group

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practice, for example, are compensation.
So the design of the compensation program, in effect, drives the economics of the business. And since the business is patient care teaching and research, that compensation program needs an economic model that compliments those missions.
Q. So is another way to say what you've put here in Paragraph 6 -- and I think the idea spills over to Paragraph 7, and I'm just trying to summarize. Are you saying that the design of the compensation program is driven by the mission --
MS. HUBBARD: Objection.
Q. -- of the academic medical center?
MS. HUBBARD: Objection.
A. In my opinion, it's the design of the compensation program's compliment mission, effect compensation program's compliment missions.
Q. Compliment missions?
A. Yup.
Q. Can you take a look at Paragraph 9, and it's the last sentence on the page. In the same vein, a principle reason academic medical centers and physician practice groups might implement

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nonqualified deferred compensation plans is to provide highly compensated physicians with a means to supplement their retirement funds and to maximize after-tax compensation." Do you see that?
A. Mm-hmm. I do.
Q. What do you mean by that statement?
MS. HUBBARD: Objection.
A. When you say what do I mean by that statement --
Q. Well, let me ask you this: What's the basis for this statement?
A. Again, in my experience where clients have their existing or adopted nonqualified retirement, nonqualified deferred compensation programs, it is most often as a means supplement retirement funds.
Q. Okay. And you say a principle reason is to do that; is that right?
A. Yes.
Q. What are other reasons?
A. Other reasons would be to provide a vehicle. Nonqualified plans, to my knowledge, as an example, are prevalent in business generally, but they are not prevalent in health care or

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academic medicine by comparison. So it does offer a distinctive advantage when recruiting a faculty member to have that enhanced retirement opportunity.
Q. And by "nonqualified plan," you mean a top-hat plan?
A. Sure.
Q. Okay.
A. A second reason is, I think, to foster retention, since that deferred compensation program is most often an asset of the corporation. So it becomes of interest to the faculty to ensure that that corporation is a going concern so that it can foster its retention in that matter.
Q. In your opinion, are these all reasons for -- purposes for the UDC and the FRBP?
MS. HUBBARD: Objection.
A. In my opinion, they are purposes that would appear to me were likely factored into the thinking of -- it seems clearer to me from what I've read that it was perhaps maybe a bit more focused on retention than ; although, it seems that was likely an important point, too but retention seems to be.

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Q. Okay. So what, in your opinion, are the -- have we listed all of the purposes, in your opinion, for the UDC and the FRBP? Let me give you what you just gave me.
A. Sure.
Q. Okay. Supplement retirement funds?
A. Mm-hmm.
Q. vehicle?
A. Yes.
Q. Foster retention?
A. Yes.
Q. Anything else?
A. Those would be my opinion as to principle reasons for --
Q. Okay. And the among those three --
A. -- the UDC.
Q. And the FRBP?
A. Sure.
Q. Okay. And amongst those three, which in your opinion would be the primary purpose for the UDC and the FRBP?
MS. HUBBARD: Objection.
A. I'm not real comfortable saying that there's a primary purpose because these are

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interrelated purposes. They don't -- they're not mutually exclusive. However, I would believe that the primary purpose was probably supplemental retirement.
Q. And what do you --
A. But generally, I think they're all interrelated.
Q. Okay. What do you base that on that it was probably supplemental retirement?
A. I base that on my experience, where that is most often the case and some of the depositions -- some of the materials in the deposition I read.
Q. What are you referencing from the depositions?
A. The fact that we -- BSG developed and modified the deferred compensation program, in part, in response to changes in regulatory environment in order to -- as I remember, to the best of my recollection as it was described, in order to keep folks whole and provide additional retirement opportunity.
Q. Which deposition are you referring to?
A. I believe it was Dr. Mannick's. Again,

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that's to the best of my recollection.
MS. HUBBARD: Colleen, can we take a short break when we're at a good breaking point?
MS. COOK: Yeah. We sure can, but I'm probably almost done.
MS. HUBBARD: Oh, okay. That's fine then.
MS. COOK: I mean, we can take a break because then I can just -- take five minutes, and I can assess and probably finish up faster.
MS. HUBBARD: Sure.
MS. COOK: Do you want to do it now?
MS. HUBBARD: Sure. That sounds great.
(Brief recess taken)
BY MS. COOK:
Q. Mr. Sadowski, we've touched on your experience with top-hat plans throughout the course of this deposition.
Can you tell me what is the extent of your experience with top-hat plans, aside from recommending them to academic medical centers and your consultation?
A. Sure. My experience is generally in that regard.

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Q. Okay.
A. As well as in acknowledging the realities -- factoring in the realities of the plan into a compensation program design, if there's an existing one in place.
Q. Would you be involved in the negotiation of a top-hat plan?
A. Not the specific negotiation of a top-hat plan.
Q. Anything else that you can think of relating to your experience with top-hat plans that we haven't discussed already today?
A. Generally, I don't believe so.
MS. COOK: Could you mark that, please.
(Document marked as Sadowski Exhibit 2 for identification)
Q. Mr. Sadowski, if you could please take a look at this document. Do you recognize this document?
A. I do not.
Q. Can I direct your attention, please, to Page No. 4, the bottom paragraph. It says, "Mr. Sadowski, who advises both academic medical centers and individuals, physicians on compensation